Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: NORTHWEST TEXAS HOSPITAL 3255 WEST PIONEER PARKWAY ARLINGTON TX 76013	MFDR Tracking #: M4-08-7212-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: ACE FIRE UNDERWRITERS INS CO Box #: 15	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the base APC rate of $2900.10 for APC # 1054. Allowing this at 143% would yield a fair and reasonable allowance of $4147.14."

Amount in Dispute: $3,047.14

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Coventry's Clinical Validation Department has reconsidered the above mentioned dates of service and have determined that the original review was accurate. Charges for the facility in which the provider elected to have procedures or surgery performed on an outpatient basis are paid at a fair and reasonable amount pursuant to the criteria set forth in Section 413.011(b) of the Texas Workers Compensation Act." "It has been determined that Coventry will stand on our original recommendation of $900.00."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
2/27/2008	150, 850-243, M, 900-030, W2, 850-328, W4, 920-002	Hospital Outpatient Services	$3,047.14	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective January 17, 2008 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on July 15, 2008.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
   - 150-Payer deems the information submitted does not support this level of service.
   - 850-243-CV: The recommended allowance reflects a fair, reasonable and consistent methodology of reimbursement pursuant to the criteria set forth in Section 413.011(D) of the Texas Workers' Compensation Act.
   - M- No MAR.
   - 900-030-CV: This charge was reviewed through the clinical validation program.
   - W2-Workers' Compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment.
   - 850-328-CV: Venipuncture is included in the laboratory fee.
   - W4-No additional reimbursement allowed after review of appeal/reconsideration.

- 920-002-In response to a provider inquiry, we have re-analyzed this bill and arrived at the same recommended allowance.

2. The respondent denied reimbursement for venipuncture services with EOB denial reason codes "W2". The Division finds that on the reconsideration EOBs, the respondent maintained these denial reason codes. The Division finds that the respondent has not disputed the compensability of the service with the Division; therefore, EOB denial reason code "W2" is not supported. The disputed service will be reviewed in accordance with Division rule at 28 TAC §134.1.

3. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective January 17, 2008, 33 TexReg 428, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

5. Division rule at 28 TAC §133.307(c)(2)(C), effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division." Review of the documentation submitted by the requestor finds that the requestor has indicated that the amount billed for the services in dispute is the total for all services charged on the hospital bill; however the documentation does not support that all of the services in dispute were rendered on the date of service listed on the requestor's *Table of Disputed Services*. The requestor listed the disputed date of service as 2/27/08 on the *Table;* the total charges on the bill were for date of service 2/25/08 and 2/27/08. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed under Division rule at 28 TAC §133.307(c)(2)(C).

6. Division rule at 28 TAC §133.307(c)(2)(F)(iv), effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(c)(2)(F)(iv).

7. Division rule at 28 TAC §133.307(c)(2)(G), effective May 25, 2008, 33 TexReg 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

   - The requestor's position statement states that "Understanding that TWCC is wanting to move to a hospital reimbursement of a %-over-Medicare, we have used that methodology in our calculation of fair and reasonable. Medicare would have reimbursed the provider at the base APC rate of $2900.10 for APC # 1054. Allowing this at 143% would yield a fair and reasonable allowance of $4147.14."
   - The requestor does not discuss or explain how payment of 143% of Medicare allowable would result in a fair and reasonable reimbursement.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - The requestor did not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.
   - The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
   - The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the proposed methodology.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the

requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(C), §133.307(c)(2)(F)(iv) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

		10/12/2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.